		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001636

Facility Name: CHAMPAIGN COUNTY NURSING HOME

Address: 1701 East Main Street (Number) Urbana (City) 61802-2836 (Zip Code)

County: Champaign

Telephone Number: (217) 384-3784 **Fax #** (217) 337-0120

IDPA ID Number: 36-6006910

Date of Initial License for Current Owners: 4/26/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven D. Tenhouse, Olive LLP **Telephone Number:** (217) 753-1375

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jeremy Maupin
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Olive LLP
(Firm Name & Address) 205 S. 5th Street, Suite 645, Springfield, IL 62701
(Telephone) (217) 753-1375 Fax # (217) 744-0193

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,998	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)	34	12,444	5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,938	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,795	1,467	2,016	6,278	8
9	SNF/PED					9
10	ICF	31,746	32,289		64,035	10
11	ICF/DD					11
12	SC	1,506	3,342		4,848	12
13	DD 16 OR LESS					13
14	TOTALS	36,047	37,098	2,016	75,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.51%

D. How many bed-hold days during this year were paid by Public Aid?
90 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care, Child Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1943

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 153 and days of care provided 2,016

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A - exempt Fiscal Year: 11/30

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	602,851	60,477	1,748	665,076		665,076	(1,488)	663,588			1
2	Food Purchase		428,140		428,140	(59,302)	368,838	(42,196)	326,642			2
3	Housekeeping	380,386	34,732		415,118		415,118	(3,329)	411,789			3
4	Laundry	107,085	42,805		149,890		149,890		149,890			4
5	Heat and Other Utilities			270,884	270,884		270,884	(25,964)	244,920			5
6	Maintenance	48,940	12,134	159,877	220,951		220,951	(16,487)	204,464			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,139,262	578,288	432,509	2,150,059	(59,302)	2,090,757	(89,464)	2,001,293			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,438,819	204,302	645,313	3,288,434		3,288,434		3,288,434			10
10a	Therapy	65,264	3,401		68,665	67,113	135,778		135,778			10a
11	Activities	164,360	2,221		166,581		166,581		166,581			11
12	Social Services	97,311	1		97,312		97,312		97,312			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,765,754	209,925	645,313	3,620,992	67,113	3,688,105		3,688,105			16
	C. General Administration											
17	Administrative	56,290		43,547	99,837		99,837	(1,664)	98,173			17
18	Directors Fees											18
19	Professional Services			47,729	47,729	(498)	47,231	(1,824)	45,407			19
20	Dues, Fees, Subscriptions & Promotions			38,349	38,349	498	38,847	(912)	37,935			20
21	Clerical & General Office Expenses	290,932	25,235	39,093	355,260		355,260	(4,447)	350,813			21
22	Employee Benefits & Payroll Taxes			962,252	962,252	59,302	1,021,554	(67,811)	953,743			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,959	12,959		12,959		12,959			24
25	Other Admin. Staff Transportation			270	270		270	(10)	260			25
26	Insurance-Prop.Liab.Malpractice			35,409	35,409		35,409	(5,262)	30,147			26
27	Other (specify):*											27
28	**TOTAL General Administration**	347,222	25,235	1,179,608	1,552,065	59,302	1,611,367	(81,930)	1,529,437			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,252,238	813,448	2,257,430	7,323,116	67,113	7,390,229	(171,394)	7,218,835			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME #0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			277,321	277,321		277,321	(40,653)	236,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,491	5,491		5,491		5,491			35
36	Other (specify):* Loss on disposal			2,541	2,541		2,541	(2,541)				36
37	TOTAL Ownership			285,353	285,353		285,353	(43,194)	242,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,709	132,243	239,952	(67,113)	172,839		172,839			39
40	Barber and Beauty Shops	36,612	1,867		38,479		38,479		38,479			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,742	114,742		114,742		114,742			42
43	Other (specify):* Adult & Child Day Care			336,364	336,364		336,364	(336,364)				43
44	TOTAL Special Cost Centers	36,612	109,576	583,349	729,537	(67,113)	662,424	(336,364)	326,060			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,288,850	923,024	3,126,132	8,338,006		8,338,006	(550,952)	7,787,054			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(31,954)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(100)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(662)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(250)	20		28
29	Other-Attach Schedule	(517,986)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (550,952)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense		31	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (550,952)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CHAMPAIGN COUNTY NURSING HOME
ID# 0001636
Report Period Beginning: 12/1/99
Ending: 11/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	(Gain)/Loss on Sale of Assets	$ (2,541)	36	1
2	Non-care related depreciation	(7,390)	30	2
3	Miscellaneous income	(1,889)	21	3
4				4
5				5
6				6
7				7
8	DAY CARE:			8
9	Dietary	(1,488)	1	9
10	Food	(10,242)	2	10
11	Housekeeping	(3,329)	3	11
12	Utilities	(25,964)	5	12
13	Maintenance	(16,487)	6	13
14	Administrative	(1,664)	17	14
15	Professional fees	(1,824)	19	15
16	Office	(2,458)	21	16
17	Employee Benefits	(67,811)	22	17
18	Staff Transportation	(10)	25	18
19	Insurance	(5,262)	26	19
20	Depreciation	(33,263)	30	20
21	Day Care	(336,364)	43	21
22				22
23				23
24				24
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89				89
90	**Total**	(517,986)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,488)	0	0	0	0	0	0	0	0	0	0	(1,488)	1
2	Food Purchase	(42,196)	0	0	0	0	0	0	0	0	0	0	(42,196)	2
3	Housekeeping	(3,329)	0	0	0	0	0	0	0	0	0	0	(3,329)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(25,964)	0	0	0	0	0	0	0	0	0	0	(25,964)	5
6	Maintenance	(16,487)	0	0	0	0	0	0	0	0	0	0	(16,487)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(89,464)	0	0	0	0	0	0	0	0	0	0	(89,464)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,664)	0	0	0	0	0	0	0	0	0	0	(1,664)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,824)	0	0	0	0	0	0	0	0	0	0	(1,824)	19
20	Fees, Subscriptions & Promotions	(912)	0	0	0	0	0	0	0	0	0	0	(912)	20
21	Clerical & General Office Expenses	(4,447)	0	0	0	0	0	0	0	0	0	0	(4,447)	21
22	Employee Benefits & Payroll Taxes	(67,811)	0	0	0	0	0	0	0	0	0	0	(67,811)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(10)	0	0	0	0	0	0	0	0	0	0	(10)	25
26	Insurance-Prop.Liab.Malpractice	(5,262)	0	0	0	0	0	0	0	0	0	0	(5,262)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(81,930)	0	0	0	0	0	0	0	0	0	0	(81,930)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(171,394)	0	0	0	0	0	0	0	0	0	0	(171,394)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(40,653)	0	0	0	0	0	0	0	0	0	0	(40,653)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,541)	0	0	0	0	0	0	0	0	0	0	(2,541)	36
37	**TOTAL Ownership**	(43,194)	0	0	0	0	0	0	0	0	0	0	(43,194)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(336,364)	0	0	0	0	0	0	0	0	0	0	(336,364)	43
44	**TOTAL Special Cost Centers**	(336,364)	0	0	0	0	0	0	0	0	0	0	(336,364)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(550,952)	0	0	0	0	0	0	0	0	0	0	(550,952)	45

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Treasury Services	$ 3,046	Champaign County	100.00%	$ 3,046	$	1
2	V	17	Auditor's Office Services	40,501	Champaign County	100.00%	40,501		2
3	V	22	IMRF	113,258	Champaign County	100.00%	113,258		3
4	V	22	FICA	341,126	Champaign County	100.00%	341,126		4
5	V	22	Workers Compensation	87,342	Champaign County	100.00%	87,342		5
6	V	22	Unemployment Insurance	47,658	Champaign County	100.00%	47,658		6
7	V	22	Health Insurance	362,487	Champaign County	100.00%	362,487		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 995,418			$ 995,418	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOMI # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County
Street Address: 1776 East Washington
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3776
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Treasury Services	Direct Cost		All Co. Depts.	$	$		$ 3,046	1
2	17	Auditor's Office Services	Direct Cost		All Co. Depts.				40,501	2
3	22	IMRF	Direct Cost		All Co. Depts.				113,258	3
4	22	FICA	Direct Cost		All Co. Depts.				341,126	4
5	22	Workers Compensation	Direct Cost		All Co. Depts.				87,342	5
6	22	Unemployment Insurance	Direct Cost		All Co. Depts.				47,658	6
7	22	Health Insurance	Direct Cost		All Co. Depts.				362,487	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 995,418	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County Day Care
Street Address: 1701 East Main Street
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3784
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	281,424		$ 62,225	$	6,732	$ 1,488	1
2	2	Food	Meals	281,424		428,140		6,732	10,242	2
3	3	Housekeeping	Square feet	63,455		34,732		6,082	3,329	3
4	5	Utilities	Square feet	63,455		270,884		6,082	25,964	4
5	6	Maintenance	Square feet	63,455		172,011		6,082	16,487	5
6										6
7	17	Administrative	Revenue	7,726,730		43,547		295,296	1,664	7
8	19	Professional Fees	Revenue	7,726,730		47,729		295,296	1,824	8
9	21	Office	Revenue	7,726,730		64,328		295,296	2,458	9
10	22	Employee Benefits	Salaries	4,614,002		962,252		325,152	67,811	10
11	25	Staff Transportation	Revenue	7,726,730		270		295,296	10	11
12	26	Insurance - Auto	Direct Allocation	1		4,064		1	4,064	12
13	26	Insurance - Other	Revenue	7,726,730		31,345		295,296	1,198	13
14	30	Depreciation - Auto	Direct Allocation	1		7,391		1	7,391	14
15	30	Depreciation - Other	Square feet	63,455		269,930		6,082	25,872	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,398,848	$		$ 169,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 101,931 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ADULT DAY CARE AND CHILD DAY CARE - 6082 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Grounds	1,829,520	1865	$ 2,100	1
2					2
3	TOTALS	1,829,520		$ 2,100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	153		1973	1973	$ 2,085,435	$		$	$	$	4
5	56		1910	1971	734,760						5
6	34			1971	207,240						6
7			1989	1989	34,891						7
8											8
	Improvement Type**										
9	Building Improvements			1972	10,300						9
10	Building Improvements			1973	146,645						10
11	Building Improvements			1974	288,473						11
12	Building Improvements			1974	18,482						12
13	Building Improvements			1975	25,353						13
14	Building Improvements			1976	6,342						14
15	Building Improvements			1977	3,399						15
16	Building Improvements			1977	8,548						16
17	Building Improvements			1980	2,469						17
18	Building Improvements			1981	36,818						18
19	Building Improvements			1982	57,322						19
20	Building Improvements			1983	31,084						20
21	Building Improvements			1984	223,983						21
22	Building Improvements			1985	57,958						22
23	Building Improvements			1986	254,092						23
24	Building Improvements			1987	81,739						24
25	Building Improvements			1988	345,563						25
26	Building Improvements			1989	64,947						26
27	Building Improvements			1990	251,292						27
28	Building Improvements			1991	163,384						28
29	Building Improvements			1992	138,101						29
30	Building Improvements			1993	62,716						30
31	Building Improvements			1994	360,106						31
32	Building Improvements			1995	28,420						32
33	Building Improvements			1996	21,058						33
34	Parking Lot			1977	25,035						34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,775,955	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tree Care			1981	465						9
10	Landscaping additions			1982	1,870						10
11	Landscaping additions			1983	5,250						11
12	Landscaping additions			1987	3,491						12
13	Landscaping additions			1988	1,971						13
14	Landscaping additions			1989	6,125						14
15	Landscaping additions			1990	3,596						15
16	Landscaping additions			1991	11,069						16
17	Landscaping additions			1992	2,969						17
18	Parking Lot Expansion			1996	67,139						18
19	Smoke detectors			1997	4,524						19
20	Redecorating - ADC			1997	1,459						20
21	Sprinkler Backflow Preventor			1997	6,230						21
22	Fire Door - Activities Office			1997	626						22
23	Wall - Dietary			1997	705						23
24	Mini Blinds - Dining Area			1997	1,045						24
25	Tuckpointing - Administration Building			1997	11,400						25
26	Flooring Improvements			1997	3,306						26
27	Asbestos Removal			1998	45,350						27
28	Project Planning - ARD Expansion			1998	35,513						28
29	Air Conditioning - Chiller Replacement			1998	193,621						29
30	Hot Water Treatment Equipment			1998	1,422						30
31	Pipe Insulation			1998	3,201						31
32	Door Sensor Beam			1998	567						32
33	Vanity Replacement (Wing)			1998	16,236						33
34	Shower Tile Replacement (B-wing)			1998	1,064						34
35	Heat Exchanger Replacement			1998	4,417						35
36	TOTAL (lines 4 thru 35)				$ 434,631	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pipe Insulation			1998	97						9
10	Asbestos Removal			1998	4,792						10
11	Cable for Computers			1999	7,350						11
12	Chiller Replacement Electrical			1999	3,465						12
13	Door Alarm on B-wing			1999	1,808						13
14	Carpet - 3 offices			1999	814						14
15	Door Alarm Hook-up			1999	50						15
16	Stainless Steel Wall Coverings			1999	1,382						16
17	Flipper Cabinet W/Hang Tracks			1999	297						17
18	Flipper Cabinet W/Hang Tracks			1999	1,216						18
19	Door Magnets (Door Alarm)			1999	144						19
20	Ceramic Flooring			1999	3,192						20
21	Carpet in 2 offices			1999	918						21
22	Hollow Metal Door			1999	788						22
23	Annunciator			1999	400						23
24	Unit Heater for Bus Barn			1999	569						24
25	Privacy Panels & Hardware			1999	518						25
26	A-wing Nurses Station			1999	4,333						26
27	Hook-up Call System			1999	734						27
28	Computer cable			2000	810						28
29	Stainless steel molding for shower rooms			2000	578						29
30	Vinyl flooring			2000	960						30
31	Concrete fountain			2000	1,000						31
32											32
33	Depreciation			2000		170,977		170,977		4,082,941	33
34	Less: Disallowed assets				(206,718)					(206,718)	34
35	Less: Allocation to day care					(33,263)		(33,263)			35
36	TOTAL (lines 4 thru 35)				$ (170,503)	$ 137,714		$ 137,714	$	$ 3,876,223	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,363,056	$ 95,453	$ 95,453	$		$ 1,011,804	37
38	Current Year Purchases	57,687	3,501	3,501			3,501	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,420,743	$ 98,954	$ 98,954	$		$ 1,015,305	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 7,462,926	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 236,668	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 236,668	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,891,528	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,491 Description: Trash compactor $3,216; APP Concentrator $460; IV Pump $240; Cont. Passive Motion $1,575
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 34,376	$		$ 34,376	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,334			3,334	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			27,420			27,420	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				59,111		59,111	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical supplies	39-2					48,598		48,598	13
14	TOTAL			$		$ 65,130	$ 107,709		$ 172,839	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 514,576	$	1
2	Cash-Patient Deposits	24,426		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	866,789		3
4	Supply Inventory (priced at cost)	59,841		4
5	Short-Term Investments	1,699,983		5
6	Prepaid Insurance	7,325		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Other Funds	8		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,172,948	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,246,803		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,885,991		16
17	Accumulated Depreciation (book methods)	(5,516,102)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,616,692	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,789,640	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 633,260	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,426		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Other Funds	131,591		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 789,277	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 789,277	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,000,363	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,789,640	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,240,140	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,240,140	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,775)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(2)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (239,777)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,000,363	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,431,434	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,431,434	3
	B. Ancillary Revenue		
4	Day Care	295,296	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 295,296	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,648	13
14	Non-Patient Meals	31,954	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	132,439	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 197,041	23
	D. Non-Operating Revenue		
24	Contributions	24,130	24
25	Interest and Other Investment Income***	130,406	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 154,537	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Charge, NSF Check Charge	18,033	28
28a	Miscellaneous Revenue	1,889	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,923	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,098,231	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,150,059	31
32	Health Care	3,620,992	32
33	General Administration	1,552,065	33
	B. Capital Expense		
34	Ownership	285,353	34
	C. Ancillary Expense		
35	Special Cost Centers	614,795	35
36	Provider Participation Fee	114,742	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,338,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,775)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,775)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,015	2,625	$ 67,913	$ 25.87	1
2	Assistant Director of Nursing	1,808	2,032	41,375	20.36	2
3	Registered Nurses	36,672	41,293	787,129	19.06	3
4	Licensed Practical Nurses	23,917	27,143	373,857	13.77	4
5	Nurse Aides & Orderlies	105,589	119,904	1,082,998	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,308	6,102	65,264	10.70	8
9	Activity Director	15,198	15,739	164,360	10.44	9
10	Activity Assistants					10
11	Social Service Workers	5,987	6,306	97,311	15.43	11
12	Dietician					12
13	Food Service Supervisor	66,454	72,286	602,851	8.34	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,168	4,569	48,940	10.71	17
18	Housekeepers	37,230	42,170	380,386	9.02	18
19	Laundry	11,932	13,409	107,085	7.99	19
20	Administrator	1,632	2,590	79,865	30.84	20
21	Assistant Administrator					21
22	Other Administrative	18,768	22,496	295,756	13.15	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,781	2,090	24,268	11.61	31
32	Other Health C: Dental Hygientist	1,607	1,620	32,880	20.30	32
33	Other(specify) Beauty Shop	3,244	3,607	36,612	10.15	33
34	TOTAL (lines 1 - 33)	343,310	385,981	$ 4,288,850 *	$ 11.11	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	58	$ 1,748	line 1, col 3	35
36	Medical Director	monthly	3,150	line 9, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	8	800	line 19, col3	38
39	Pharmacist Consultant		3,600	line 10, col 3	39
40	Physical Therapy Consultant	1,256	33,373	line 10a,col3	40
41	Occupational Therapy Consultant	960	24,867	line 10a,col3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	276	8,873	line 10a,col3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,558	$ 76,411		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	506	$ 20,906	Ln 10, Col 3	50
51	Licensed Practical Nurses	1,116	34,822	Ln 10, Col 3	51
52	Nurse Aides	30,529	586,009	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	32,150	$ 641,737		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joan Darr			$ 56,290
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,290

B. Administrative - Other

Description	Amount
Champaign County - Treasury Services	$ 3,046
Champaign County - Audit & Accounting Fees	40,501
TOTAL (agree to Schedule V, line 17, col. 3)	$ 43,547
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Meyer, Capel, Hirschfeld,		$
Muncy, Jahn & Aldeen	Legal	10,974
FR&R Consulting	Medicare consulting serv.	14,054
Senior Living Systems	Software Support	9,991
Employers Association	Compensation Sevices	5,134
Other		7,576
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,729

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,342
Unemployment Compensation Insurance	47,659
FICA Taxes	341,126
Employee Health Insurance	362,487
Employee Meals	59,302
Illinois Municipal Retirement Fund (IMRF)*	113,257
Employee Development	4,646
Employee Physicals/Lab	5,735
Less: Allocation to Day Care	(67,811)
TOTAL (agree to Schedule V, line 22, col.8)	$ 953,743

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,592
Health Care Worker Background Check	498
(Indicate # of checks performed 41)	
Nonallowable advertising/public relations	912
Books, Periodicals, Manuals	946
Dues & Licenses	11,865
Contingent Expense	15,034
Less: Public Relations Expense	(534)
Non-allowable advertising	(128)
Yellow page advertising	(250)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,935

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,959
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,959

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 Report Period Beginning: 12/1/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CHAMPAIGN COUNTY NURSING HOME # 0001636 **Report Period Beginning:** 12/1/99 **Ending:** 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $8,474; Cty Nsg Home Assoc $2,430**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **240**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,431** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **114,742**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Bray, Drake, Guthrie & Richardson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **NOT COMPLETE YET**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.